MANAGEMENT FUNCTIONS OF HOSPITAL DOCTORS

Paper Prepared by a
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for Management Efficiency in
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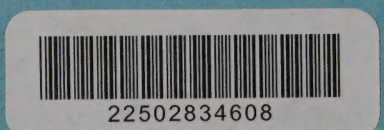

MANAGEMENT FUNCTIONS OF HOSPITAL DOCTORS

Paper presented to the Minister of Health by the Advisory Committee for Management Efficiency in the National Health Service as the result of the work of its sub-committee

Scope of this paper

1. Large organisations—industrial, commercial and financial—have in the last generation become convinced that management training is vital to efficiency; and though there are different opinions about the content, the intellectual level, the timing and the methods to be used to develop the skills of the manager, there is broad agreement about the definition of his functions. For example, a recent report (1) of the Federation of British Industries states the tasks of management as:—

(i) to discern objectives in the environment in which management is being practised and . . . . to place these objectives in some order of importance;

(ii) to devise and implement means whereby these objectives may be attained;

(iii) to devise and implement means whereby the extent and efficiency of attainment of these objectives can be measured.

Peter Drucker (2) distinguishes five basic operations in the work of the manager. A manager sets objectives, organises the work, motivates people and communicates with them; he measures the performance of his subordinates and develops them. "Every manager does these things when he manages—whether he knows it or not".

2. These, however, are general descriptions of the responsibilities confronting the industrial manager or the social administrator as he makes his way towards the top of his profession, and leaves behind the special knowledge and skills which served him at lower levels. The senior person in industry cannot progress without an

(1) Federation of British Industries. Management Education and training needs of industries—a report by an F.B.I. Working Party 1963.

(2) Drucker, Peter. "The Practice of Management". London, 1955.

interest in management problems. The progression of the hospital doctor has a very different character. His advance depends on the development of his professional knowledge, and, although work outside the hospital on professional and public bodies might sometimes call for administrative skills he has up till now been able to reach the top without much concern for the problems of management. It is fair to say that for many doctors the detailed running of an organisation is a chore. But with the growing complexity of the medical, technical and social aspects of the Health Service as a whole and the interdependence of its parts and elements, the hospital doctor of the future will not be able to do his work without the skills and insights of the manager.

3. When the doctor makes a clinical decision about his patient, he decides in effect on a particular allocation of the resources of the hospital, whether these are human—doctors, nurses, technicians—or material—space, drugs, X-rays, etc. In the short term always, and in the long term often, these resources are circumscribed. But the needs of sick people have no natural limits, and so there must inevitably be problems about how to increase the usefulness of resources. Skill in developing and applying resources to optimum effect is part of management, and clinical decisions therefore always involve management decisions.

4. This aspect of the hospital doctor's function has been taken for granted in the past without a separate implication for the hospital, and little has therefore been published*. In medical schools and hospitals the emphasis has been on clinical training and the doctor has not been invited to look upon his function as a manager as the complement of his function as a clinician. It is the object of this note to make a preliminary study of the management role of the doctor as material for deliberation among those concerned with the training and post-graduate education of doctors, and with the organisation of medical work in hospitals.

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* Bradbeer (3), Guillebaud (4) and Porritt (5) were concerned with organisational aspects of hospital administration and did not focus the management functions of the individual doctor.

(3) Ministry of Health. Central Health Services Council. Report of the Committee on the Internal Administration of Hospitals. London, H.M.S.O. 1954.

(4) Report of the Committee of Enquiry into the Cost of the National Health Service. London, H.M.S.O. 1956.

(5) "A Review of the Medical Services in Great Britain". Report. London, Social Assay. 1962.

5. The most direct way to appreciate the management functions of hospital doctors is to consider what the doctor does in each of the main stages of training and development. Reference will be made to areas of management in which doctors could with advantage play a larger part and to the attitudes and the content of knowledge and skill in the field of management which doctors in the hospital will need to possess. It is not considered that all such attributes would be appropriate in all doctors at all grades of the service, nor that they could be fully acquired by doctors in the earliest stages of training. Though knowledge of techniques is important, the practice of management is learnt mainly by managing. Participation increases by steps, building upon the successful completion of earlier stages of growth in management and clinical skills.

The different levels of the hospital doctor

6. The hospital doctor passes through the stages of medical student, house officer, registrar, senior registrar, consultant, and each step gives him a wider horizon, and increasing responsibility for the use of resources. The culmination is to be appointed as consultant—and at this stage medical training ends, though continuing education is expected and necessary. After appointment as consultant hospital doctors become involved in a broader kind of management when they have to do with forming hospital policy. But there are wider fields yet. Some consultants will deal with the management problems of the hospital service at regional and even national level.

The medical student

7. The medical student was up till the War, essentially an apprentice in hospital, at least during the last three years of his training. He is now, for good reasons relating to changes in medical practice and to new educational needs, more of an undergraduate than an apprentice. As a student the future hospital doctor has his first, best and frequently his last, opportunity to master those basic disciplines upon which his success in management will largely depend. If he does not acquire a scientific method of thought now he probably never will. He is given his best opportunity to learn to think quantitatively. He is offered, possibly too late and at the present time in too small measure, his main chance to learn about statistics. He is introduced to the role of the medical profession in society and to knowledge of human behaviour without which his future ability to maintain effective communication in medicine will be limited. He

begins to develop attitudes towards management which are naturally conditioned by the attitudes of his teachers in the absence of any systematic exposition of the basic ideas of the subject.

The house officer

8. The newly qualified doctor, whether he intends to stay in the hospital or not, goes through pre-registration house officer posts in medicine and surgery, and may then go on to other house jobs, perhaps in the senior house officer grade. Only at these two levels are doctors part of a homogeneous group; above them the tracks begin to diverge. One man goes off into general practice; another stays on the hospital ladder and aims to become a clinical consultant or a consultant in charge of a medical service such as pathology or X-ray.

9. From the start, the junior house officer begins to take decisions which are simultaneously clinical and managerial. Although he is below the level of "discerning objectives" in his world of 30 odd beds, he is engaged in management at the level of the individual patient. In exercising his clinical skill by looking after his chief's patients, i.e. in arranging the services that each patient needs (X-rays, laboratory tests, E.C.G. examinations and the rest), certifying, notifying, interviewing and communicating generally with other parts of the hospital and with the world outside—he is carrying out many of the functions listed in the definition of the management task in paragraph 1.

10. The new house officer is often given a book of local rules, procedures and routines, together with lists of important linking organisations. This is basic information which ought always to be tabulated for his benefit but he learns the elements of management and control by experience and by precept and example from sisters, nurses, colleagues and above all from his chief. The "firm" system in British hospitals and the valuable intimacy and loyalty which the firm generates means that much of the young doctor's learning is motivated and directed by the chief with whom he is in close daily touch. His skill and his emotional attitudes are deeply affected by what he is taught or is not taught in his firm. If the chief takes an interest in bed economy, costs and competitive performance, this will indoctrinate the young man: if the chief has neither time nor the interest to go beyond the clinical field in guiding his house officers, he is influencing their outlook in a negative way by ommission. The burden of the house officer's routine and his long hours could be reduced by clerical assistance, but at least he cannot com-

plain, as industrial trainees sometimes do, that he has no real job and too little responsibility. Persons and troubles crowd through his hands, and many secondary tasks arise. He may be overworked, but he is gaining in judgement and decision and widening his experience.

11. Within the house officer's working week of 60 hours and more and in face of his varying duty periods, it is difficult to find a place for formal training. Better organisation of the clinical team would reduce the time needed to carry out his duties. At this stage of his career when, through his work with patients, with colleagues and with ancillary services, he is beginning to influence the ward scene, he should begin to think analytically about his work in terms of effectiveness, e.g. about the optimal use of beds and services, and he should be made aware of principles and objectives in the field of human relations and communications.

12. Senior house officers may have to look beyond the hospital and to consult with general practitioners about the urgency of cases on the waiting list. Before long some will enter general practice themselves where they will not only need to organise their own work under pressure, but will also make claims from outside on hospital resources. The house officer grades, senior and junior, are therefore a vital stage for the introduction of the newly graduated doctor to the principles and tools of management. It is the time of first impact, when needs can be closely related to experience. It is also the time when doctors who must later co-operate across the boundaries of their different services are currently working side by side in the same environment—the hospital. Management training must be available for them.

The registrar and senior registrar

13. The registrar's place in the clinical team is not so clear cut. The nature of his job varies so greatly from hospital to hospital and specialty to specialty that there must be research into the work of registrars before their position in the hospital structure can be fully defined. Broadly, however, a junior registrar is concerned to acquire higher qualifications. The registrar's main concern is to improve his clinical knowledge and experience; much of his time is spent in out-patient clinics or the operating theatre and he acts in clinical matters as adviser and teacher to the house officer. He begins to take responsibility for management at the level of the clinical unit. In particular, in addition to the functions already described, he may be responsible for selecting patients for admission from the waiting

list and for fixing the day for discharge. A senior registrar, though he still occupies a training post often takes more responsibility for the detailed work content of a firm than at any previous time.

14. From 6 to 8 years elapse between the house officer and consultant stages, and during this time the young man is meeting management problems at the level of the unit or department as well as at the level of the individual. He will usually have the opportunity to see health problems from the point of view of the community also. Throughout this period his management education needs to develop side by side with the acquisition of specialised clinical knowledge, so that when he becomes a consultant he is ready to manage at the departmental level.

The consultant

15. There is a distinction between the clinical consultant and the chief of a medical service department. The pathologist, the radiologist and the director of physical medicine are direct managers of departments, recognisably in charge, controlling professional and technical staff, and perhaps responsible for working within an allocation of funds. The director may delegate much or little to the chief technician or superintendent radiographer, but he carries responsibility for organising the provision of a service to his clinical colleagues and is subject to the pressure of their demands. If at times there are conflicts between quality and quantity or between priorities, he must resolve them.

16. Though there is a trend nowadays to the formation of clinical departments, most clinical consultants are not under the external pressures carried by the head of a medical service department, though they may have non-clinical commitments. Fundamentally, by training and by tradition, clinical considerations dominate their outlook. A consultant's patients may be spread over several wards and he would usually have out-patient clinics as well. At a teaching hospital he will have teaching assignments; at a non-teaching hospital he is one of the principal routes of instruction for his registrars and house officers and, in his specialty, for nursing staff also, officially or informally. Through all this his primary responsibility is to his patients, in spite of the delegation of clinical tasks to his assistants. His attention is concentrated on *this* patient *now* and *this* patient's welfare is paramount. The consultant must of course have in view the simultaneous claims of his other patients in hospital and on the waiting list, but he may not feel able to look ahead or around more widely than that. He has the professional duty to give to the particular patients in his care the best treatment he can contrive.

17. All the same, each of the consultant's decisions is a managerial decision also, because it involves a certain disposition of the hospital's resources. The consultant's work is supported by the nursing and other professional services each with its own hierarchy as well as by administrative services and clinical and laboratory departments. The situation is as described by the Chief Medical Officer of the Ministry of Health: "the individual patient usually is a part responsibility of several doctors. But one of them . . . has the overall responsibility". And it is not only doctors—"an increasing proportion of the professional work in a hospital is not medical". (6) It is not merely that the consultant directs a team. The service, and indeed the clinical skill which the doctor wishes to bring to his patient comes to fruition through the co-ordinated efforts of nurses, other doctors, administrative and clerical staff, and the many different kinds of professional, technical and ancillary staff. Because of this, consultants have an interest in the management of the whole hospital in accordance with the definition in paragraph 1.

18. One remarkable difference from other "managed" organisations is that there is no overall authority on the medical side of a hospital. The consultant, or, for that matter, the clinical department, is one of several in a competitive/collaborative relationship, entitled to help for their patients from the other professions in the hospital and with the duty to organise it. They have to secure their aims among equals. The consultant is not able, except by special gifts of personality or drive, to change more than his own parish, and the concept of a parish loses meaning where his work is divided as it sometimes is over several hospitals. The parish is better defined if the consultant is a professor with a team of assistants, or if clinical departments are created with a consultant in charge of each. Within such groups there will be authority. Otherwise the situation has some of the elements of anarchy.

19. The consultant is thus engaged in management at the level of the individual patient, at the level of the clinical unit or department and at the level of the hospital. His student days should have provided him with command of the necessary methods of thought, discipline and knowledge. His days as a house officer and registrar have given him experience of management at patient and unit or departmental levels. He is not likely as things are to have had

(6) "Some Medical Factors in General Hospital Administration", text of an address to the Annual General Meeting of the Association of Hospital Management Committees, June 1964.

experience of management at the hospital level. Once again his field has widened and he needs the help of the right curriculum and the right teaching methods. The object is to foresee needs and to arm the doctor so that he comes to the next level with foreknowledge of the problems and the methods of thought and the technical equipment to make the best contribution that he can.

20. Some consultants come to the regional or national level of policy and its execution. Once again new attitudes, knowledge and expertise are called for. It is not reasonable to expect that these can be acquired in detail solely by contact with people who have longer experience of the problems. There is a need for organised staff courses for selected consultants (and other senior officers), in which besides an opportunity to learn the problems and methods of management of the hospital and health services, the chance is given to learn how other specialties and professions have developed during the time (which may be as much as 10 years) when the consultant has been concentrating on his own field. This could enable a service fragmented by specialisation to prepare men for top management, just as the staff courses of the Armed Forces have enabled them to produce commanders and staff officers with a general view which specialisation during their earlier career had tended to discourage.

What the doctor needs to know

21. Management in the industrial organisation offers loose parallels with the hospital service, but the major differences, caused by circumstances and by history, are:—

(i) the objective is to help ill people. The hospital is a place of anxiety, for staff as well as patients. Efficiency cannot be measured in simple material terms.

(ii) The work is divided between many small and large functions which have to be planned and assembled for each patient according to his changing needs in great detail.

(iii) The work often provides the opportunity to add to knowledge.

(iv) The element of professionalism and personal responsibility in its best sense is very strong—which brings virtues but also some vices such as rigidity and the weakening of the sense of the hospital as a unity.

The industrial manager works in a more unified and clear environment; his responsibilities are more readily definable and his work more easily evaluated. The need for "playing together" is a starting

axiom and it can be backed by an authority which is part of his frame of reference. In British hospital management, these supportive and critical elements of authority are lacking.

22. What then can the consultant do about management in his hospital in his professional, single-handed place? The answer must be that he is willing,

(a) to exercise pressure on the hospital environment over which he is not a master—only an equal voice. This means working with others in discerning the objectives of the hospital and in deciding the means by which they shall be attained, c.f. paragraph 1;

(b) to plan, control and assess the work of the Department or the unit/units for the efficiency of which he is directly responsible;

(c) to support efforts to train his younger colleagues along lines suitable to the hospital of the future as that pattern becomes clear;

(d) to be responsible for assessing their performance by objective means and to subject himself to scrutiny (by himself or otherwise) and so improve his own performance.

The fact that he cares to do this will have fertilising effects beyond his personal reach, if done with tact and reason. "Improving his own performance" means,

(i) widening and deepening clinical knowledge;

(ii) cultivating the scientific habit of scrutiny of his case results, and cross-checks with colleagues;

(iii) continual efforts to ensure that in providing the best treatment and care for the patients the most efficient use is made of the limited resources of the hospital—beds, drugs, X-rays, nursing services, food, his own and other people's time;

(iv) giving knowledgeable co-operation in daily work and in planning for the future.

23. The consultant does not need to be an expert in the technicalities of other people's jobs but he needs to be alive to the impact of his own performance and the overall performance of the hospital. He should know and understand the calculation of patient stay, cost per patient week, what are fixed and what are flexible costs, norms for food costs and other norms as these are promulgated; he should know and understand the problems of recruitment, of

financial management, of staff relations and of patient relationships. He should know enough to know when sense is being talked and when nonsense, and when his own performance is short of the best and what to do. And finally, in the area known as communications, he should be aware of its importance for efficiency and for good human relations and be on guard himself against habits which make barriers.

24. Clinical knowledge and skill are the basic elements on which all else depends, But clinical decisions are always management decisions as well, and the knowledge mentioned in the last paragraph is that which the consultant needs to carry out his full functions in the hospital. The scientific habit combines a discipline and an attitude; efforts to use resources economically come from grasping a system and its problems and knowing some of the consequential techniques—co-operating with a team involves social skills. But attitudes and habits take a long time to establish, and the consultant level is too late for systematic re-education or reorientation, though it must be possible to fill gaps for young consultants or for older men who want to learn. The opportunity is offered in multi-disciplinary courses where doctors and experienced officers of the other functions in the hospital service and from other branches of the health service can study their problems side by side.

25. The possible contents of teaching fit into five main fields which together cover the attitudes, knowledge and skills which have been discussed—

(i) Appreciation of the historical evolution of the provision of medical care and of changes in functions to meet the changing demands on the three branches of the health service.

(ii) How to determine priorities and plan the use of hospital facilities, short term and long term, to the best advantage of the community and to evaluate the results achieved. (It is inescapable that clinical judgements are affected by the availability of resources.)

(iii) The controls and tools of management, in particular the creative use of costs and statistics in the clinical as well as in the administrative field.

(iv) How to keep communication with all other hospital staff and with patients alive and human and two-way; this is vital because of the loose structure of the hospital and even more so because of the presence of anxiety.

(v) How to see oneself as part of a changing situation subject in all its parts to constant scrutiny and reassessment of method and of aims and with a growing emphasis on measurement of performance.

All this is apart from induction into the routine daily operation of the hospital, which is a separate question.

Training in management

26. Education for management in industry and business has proliferated in many forms such as courses run by companies for their own people; courses run by some professional institutions for registered students; and by technical institutions with full public access. The range is now being extended by the universities and the relatively new business schools. Variety is natural, all the more because there are all kinds of individual requirements, wide and narrow. Rapid evolution has brought problems which the health service will come to know—of discovering need, deciding on objectives, finding the right teaching methods and, more important, finding and training the right teachers.

27. The hospital service is to varying degrees going along with these developments. The training of administrators has become the concern of the National Staff Committee, and the Salmon Committee has reported on the needs of nursing administration. But so far hardly anything has been done for the hospital doctors. The Hospital Administrative Staff College has held two or three courses for consultants and registrars and they, together with the Nuffield Centre for Hospital and Health Service Studies at Leeds and a few hospital boards have included hospital doctors in management training but the numbers involved up till now are small. These efforts are not however to be looked upon as insignificant, if they show a new climate in hospital medicine. Less authoritarian teaching, the growth of research and postgraduate medical education in Regional Hospital Board hospitals, and the development of a more critical approach to operations and to clinical work—all these favour new outlooks and encourage scepticism about the established system where the doctor is given little preparation for management because this is not regarded as a major function.

28. For the purpose of this paper, training needs have been treated broadly in the belief on the one hand that those more expert in the teaching and training world must be asked for their contribution and on the other that a variety of approaches and methods at different levels is necessary as well as continuous research into

requirements. The concept of levels suggests that in the years of professional training time must be allowed at all stages for systematic study of the management field in the hospital service. At the earliest stage—student and house officer—doctors who will leave hospital to go into the general medical practitioner or the local authority service will work alongside those who will stay. This is entirely for the good. There are areas of training for the general practitioner and for the local authority doctor just as for the future consultant. No one can doubt that ways of closer integration at later stages in these three services must be found. We hope that the Royal Commission on Medical Education will be able to make room in the crowded syllabus of the student, and in the busy life of the house officer, for training of this kind to be brought to the help of the future doctor.

29. At registrar and consultant levels management training will find its place in postgraduate centres, but a substantial part must be multi-disciplinary so that people who have to work together train together. This must apply also to administrators from the Ministry so that all members of the hospital team gain insight, and widen and deepen sympathy with their colleagues and try to think in terms of total social cost. The distribution of doctors and the small sizes of some groups suggest that management training must often be concentrated at convenient centres. To the benefit of all, use must be made of the facilities for management education now available in institutions and colleges.

30. This review has shown that the hospital doctor should be given organised training in the management of the resources of the health service in order to produce the maximum good for the community. He will continue to learn much from experience, but in the hospital world as elsewhere there must be a steady effort to put the learner in touch with the best experience by finding good habits and techniques and promulgating them: by moving what can be safely moved from the area of immediate experience to the area of teaching. In fact what can be said about training for other work applies to the doctor in his management role—and not least because medical manpower will be short and the doctor will have to use his special skill with maximum purpose and effect.

31. The objectives of a training programme are to develop constructive attitudes of mind and to acquire knowledge and perspective in handling the organisation, the resources, the relationships and the tools which are available. This training must begin with the

student, continue through the levels of the house officer, registrar, senior registrar and consultant with no feeling that learning ends at any level.

32. On the industrial side it is not only that training for management is more and more accepted as necessary in itself. It is important also because the rate of social and technological change is rising and many forces combine to keep it high. Simultaneously, industrial management is moving in the direction of logical analysis, of solutions refined by examining and discarding alternatives, for example on computers, of positive planning for formulated objectives, of examining situations against total background: in short, of much less "hunch" and much more measurement. These influences may cause a new managerial revolution. They are at work in the health service where the management structure is just as liable to change to meet the needs of changing times. So long as the emphasis is dynamic and not static, management training must help the doctor and his colleagues in the hospital to expand and develop their joint service to the community.

NOTES

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